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DOCTORS' DILEMMAS

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THE SIR THOMAS AND LADY EDITH DIXON MEMORIAL LECTURE

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I SHOULD like to begin my talk to-day by quoting some words first written shortly before I was born. "Never has the outlook for the profession been brighter. Everywhere the physician is better trained and better equipped than he was 25 years ago. Disease is understood more thoroughly, studied more carefully and treated more skilfully. The average sum of human suffering has been reduced in a way to make the Angels rejoice. Diseases familiar to our fathers and grandfathers have disappeared. The death rate for others is falling to vanishing point, and public health measures have lessened the sorrows of millions. Vagaries and whims, lay and medical may neither have diminished in number nor lessened in their capacity to distress the fainthearted, who do not appreciate that to the end of time people must imagine vain things, but they are dwarfed by the comparison with the colossal advances of 50 years". If William Osler had been writing in 1973, he could well have used identical language. We tend to think that the progress in our generation has been more dramatic and vital than at any time in history, but the impact on medicine of the triple discoveries of antiseptics, anaesthesia and X-rays, must have been as great in the second half of the nineteenth century as has been the discovery of antibiotics in the first half of the twentieth. What, however, distinguished the present situation from that which existed in the last century and centuries before is the changing pattern in the relationship between the doctor and the society in which he works, and it is on this which I should like to concentrate to-day.

It has been said "the basis of medicine is sympathy and the desire to help others. Whatever is done to this end must be called medicine."

"In the primal sympathy
Which having been, must ever be
In the soothing thoughts that spring
Out of human suffering."

Herein lies the fundamental motivation for most of us into the profession of medicine. To primitive man disease only struck when the individual became possessed of some devil or evil genius. The first task of the medicine man was to drive out the bad spirits by various forms of magic and incantations. Having done that he had to proceed to drive out the physical badness; and I suspect that is why, over the centuries so much of therapy has resided in emetics, purges enemata, diuretics, diaphoretics and venesection. Furthermore in the earliest civilisations medicine was a pre-eminent social force. The medicine man was the one who led his tribe in its struggle against misfortune. Cast in this role he was like the politicians and generals of later years—in order to survive he had to be successful.

The next stage in the evolution of the physician found both patient and doctors looking towards religion and philosophy rather than to science in the endeavours to cure illness. "Physic was early fathered upon the Gods"—and so we find, first Imhotep the Egyptian God of medicine followed by Asklepios in the Grecian cult. He was the son of Apollo whose shrines housed the prophetic serpents, which have remained through the centuries symbolic of supernatural powers, and which to this day characterise so many of the seals and charters of medical organisations. His daughter, Hygiea, was a more cheerful character and in her resided the concept that cleanliness, fresh air and nature's beauty spots were all designed as the natural venues for the prevention of disease. Small wonder then, that it was in one of these beauty spots on the sunny shores of the bright blue Aegean Sea, the island of Cos, that the Father of Medicine was born, reared, practiced and taught. Here for the first time the systematic observation of the natural progress of diseases was practiced and the observations recorded. The effects of treatment and the prognosis of many illnesses were documented for the benefit of future generations. Clinical medicine was born and thenceforward for many centuries the place of the physician was with the individual patient in the sick room. However, success in diagnosis and treatment remained the yardstick whereby he was judged by his contemporaries. The "lex talionis" originating as the code of Hammurabi (2,000 years B.C.) left no doubt of the principle of an eye for an eye and a tooth for a tooth. "If a doctor has treated a gentleman for a severe wound with a bronze lancet and has cured him, or has opened an abscess of the eye for a gentleman with a bronze lancet, and has cured the eye of the gentleman, he should take 10 Shekels of silver. If on the other hand a doctor has treated a gentleman for a severe wound with a bronze lancet and has caused (notice the word 'caused') the gentleman to die, or has opened an abscess of the eye for a gentleman and caused (again) the loss of the eye, then one should cut off his right hand". As late as 1650 a Chinese Physician who lost a royal patient was buried alive with his patient! In the section that deals with fees in the recent report of the Monopolies Commission, it is not without interest and perhaps significance that the suggestion is made that a greater degree of competition within the professions (including medicine) in regard to fees based upon results might not in fact be against the public interest by promoting greater efficiency. How much has Society's attitude to the practitioner of the noble art of healing changed in 4,000 years?

In any society changes can be brought about by either revolution or evolution—and we have seen both in the present generation, in medicine as in other spheres.

In 1948 the introduction of a National Health Service was indeed a revolution in the practice of medicine. It was, I think most people will agree, a bold, imaginative and courageous step, which has, in the event, had more on the credit than on the debit side of the account, in the 25 years of its existence. The political architect of the Health Service said at the time that it would take 25 years for the revolution he was creating to settle down, and for all the teething troubles to be ironed out. That, like many another political prophesy, has proved to be a serious underestimate, and the reorganisation proposed for 1974 bid fair to give the cauldron another good stir. I think there is a tendency to forget just what a revolution this event created for the medical profession, especially as it was introduced on an appointed day with remarkably little preparation. There were three fundamental changes brought about. First of all, although it removed the necessity for any consideration of finance at the time of discharging any item of service, it erected a different sort of barrier between patient and doctor—namely the State, which now became responsible for payment. I shall return to this point later because as time has passed it has caused more rather than fewer problems. The second big change that occurred was to bring medicine within the ambit of politics. It is vain to protest that medicine and politics have nothing in common and are mutually incompatible. They may be strange bed-fellows but nevertheless they are bed-fellows for better or for worse. How much of the national resources are to be devoted to the health service is a political decision, not a medical one. The National Health Service began by costing something over 200 million pounds a year. The designer of the welfare state, "from the cradle to the grave" made what must rank as one of the major miscalculations of all time, when he argued that as the nation became healthier, the cost of the health service would fall, not rise. The rising cost of the health service, 10-20 times more than intially, is due only in a very small part to the inflationary situation in other areas. It is in part due to the much greater degree of sophistication that has developed with technological advances in a wide variety of medical and surgical techniques both of diagnosis and treatment. These are inevitably vastly more expensive than the stethoscope and bottles of medicine of yesteryear. But more and more the rising costs reflect the steadily rising and totally insatiable demand by the public for medical services. It is impossible to foresee any ceiling to this demand. As the more serious diseases recede in both severity and incidence, minor ailments replace them in ever increasing numbers, and who would be brave enough to forecast the disappearance of the thousand and one "malade imaginaires?"

It is no part of the doctor's traditional responsibility to try to restrict these demands. Only Government, by deciding how much of the revenue of the nation can be made available to meet these ever increasing demands, can exercise any sort of control.

The third change that came about in 1948 was the division of the profession into two distinct halves—the general practitioners on the one hand and the hospital doctors on the other. Although both are engaged in the clinical practice of the art and science of medicine, the difference in the relationship that each has with their employer in regard to finance has exercised a subtle influence over the years—an influence that the profession itself has tried to play down. The hospital doctor,

whether he be full-time or part-time is in direct contract with the State as his employer. He has a proper career structure, with the stimulus of competition for promotion and status, the prospects of financial progress by incremental increases based not only on length of service, but also upon merit and quality of service. The general practitioner on the other hand has clung to, and still clings to the 'sacred cow' of being an independent contractor. If one examines the position critically, the family doctor has little real competitive rewards for the practice of good medicine, precisely because of this financial situation. In fact, paradoxically, in some ways the better he equips himself with the wherewithall to practice good medicine by modern standards, the worse off he is. Short of some serious or gross negligence he receives little censure for the practice of poor medicine and even less reward for the practice of good medicine. His main competitive driving force is competition for more patients because more patients mean more money. As a previous Minister of Health has written "The situation of the family doctor therefore combines private enterprise and state service without the characteristic advantages of either—the essence of private enterprise system, competition for gain has been gouged out of family doctoring, while leaving the empty shell". This may seem a harsh criticism, but it is a criticism of a system, not of individual doctors. Because the great majority are dedicated professionals, devoted to the care of their patients, the means that have perforce been introduced over the years to provide the necessary finance for a secure livelihood have created a system of special payments and grants that is surely a financier's nightmare. Apart from disrupting the smooth workings of relationships with patients and other members of the profession, it has created the impression with the public that the only thing the doctor is interested in is money. And in some ways the situation is getting worse rather than better, and at a time when unity within the profession is of paramount importance. Even further schisms are arising with junior hospital doctors, regional consultants and other groups hiving themselves off—and all arguing fundamentally about one thing—money. To those with the best traditions of medicine at heart, it is a scene that inevitably calls for concern and demands some action.

I should now like to turn from the revolution to the processes of evolution that are having such a marked effect upon the practice of medicine in our generation, and which are creating problems as well as solving them. I do not need to remind you of all the technological advances applicable to the care of patients, in diagnosis as well as in treatment, but merely to exemplify my point by a few examples. The application of scientific technology to parturition should in theory bestow great benefit on the next generation. The labour ward with all the paraphernalia of controlled labour and foetal monitoring is an awe-inspiring place. The operating theatre, with advanced vascular or transplantation surgery in progress is demanding the services of large teams of highly trained experts. The intensive care units, whether for newborn babies, for the victims of road accidents or natural disease, are making enormous demands upon the resources of our hospital services. Clinical and laboratory research is becoming the sine qua non of medical practice—even to the point of obsession. There is a tendency to forget that research should be related to the needs of the patient. Research which is not so related may well be research, but it is not clinical research. There is a modern obsession in medicine

to-day that no fact is thought to be a fact until it has been the subject of a controlled trial. I do not want in any way to belittle the enormous contributions that modern scientific technology is making to the control and cure of disease, and the improvement of health, but I do want to emphasise that apart from the enormous costs involved, there is not always enough thought given to long term effects of much that is being done, both on the individual and the community. Where the benefit, actual or potential, to the individual coincides with that to the community, no problems and no dilemmas arise. It is in the interests of both the parent of a child and the society in which it will live that it be born healthy rather than deformed. Any steps therefore, taken to this end are welcome by both, and no limits should be placed upon the resources made available to help achieve this end. But the interests do not always coincide. The doctor by instinct and by training is an individualist and the benefit to his patient is usually paramount to him. But in modern medicine there are many dilemmas arising and I should like to examine some of these briefly.

1. Screening for potential disease. There are two aspects of this problem—which is in fact an enormous one. It has been estimated that there are not less than 5 million in the total population, or 1 in 10 with actual disabilities which are unrecognised and untreated. If we take the figures from the Medical Research Council's Social Medicine Unit, there are upwards of 2 million in the population with untreated and undiagnosed hypertension; half a million with undetected urinary infection; 300,000—400,000 with glycosuria or abnormal blood sugar curves, more than half a million with respiratory tract disorders, and a limitless number with psychiatric morbidity. Well women's clinics and family planning clinics turn up annually a large volume of unsuspected disorders. How far should resources be directed towards efforts to uncover this large submerged iceberg of unrecognised disease? The calculation, whether in terms of economic resources or human wellbeing is an extremely difficult one to make, and because it is so difficult, such efforts as are being made are very half-hearted. But the other side of screening, namely for potential disease, that is, looking among the healthy for the potentiality to develop disease later, is even more problematical. Research has now established that the majority, even if not all, cases of cervical cancer pass through the phase of a pre-invasive lesion or carcinoma in situ. This can be detected in most cases by the application of regular cytological examination. If in the early curable stage the diagnosis is made and the appropriate treatment applied, there is the prospect of nearly 100 per cent cure—and for the individual death from cervical cancer prevented. Why then the doubts about national screening programmes? Apart from the purely scientific problem of whether *all* cervical cancers progress through the pre-invasive stage, apart from the problems of relating costs of screening programmes to the cost involved in treating cases of established disease, there still remains the problem of population motivation to come forward for investigation. So far the impact of our screening programmes in this area have been almost nil in terms of lowering either mortality or incidence, simply because only a small section of the women at risk are being examined, and most of those that are fall into the low risk category. In the years between 1964 and 1971 the total number of women screened rose from 200,000 to 2,000,000, and yet the mortality fell from 2,465 to only 2,417—a figure of no statistical significance. Yet

in British Columbia, where a much more intensive screening programme has existed for 20 years amongst a much more static and homogeneous population, significant lowering of incidence has occurred, and it has been shown that the incidence of the disease is increased 10 times amongst those unscreened compared with those screened by cytology. In spite of this, and because of the British experience, there is a strong feeling among some, that screening programmes are a waste of time and public money, and in the face of the facts even the most optimistic campaigner must often hesitate. At the end of the day, I suspect, it may well be the politician rather than the doctor who will settle the issue by determining priorities.

2. This brings me to a second area of an increasing conflict of loyalties for the doctor—his devotion to the best and most immediate benefit of the individual patient, and his obligation to the public, society, the community—whatever term you may give to his employer. A previous Minister of Health has spelt out this dilemma for the doctor very clearly: "The professional is the servant, albeit specially equipped and endowed, while the layman (albeit often called the client) is the consumer and commands the service, and decides whether to take the advice or no". The doctor is accustomed by tradition and training to receiving patients who come to him with a complaint or a problem seeking his advice. This is being replaced more and more by patients coming to him and demanding a service, to which rightly or wrongly they feel entitled. They are encouraged in this belief because they know that the general practitioner is "contractually obliged to give all necessary care and attention gratis on demand". The ability—indeed the right—for the doctor to exercise his expert clinical judgement, based on knowledge and experience, is being more and more challenged. Better education of the public, itself an admirable development, is partly responsible for this changed approach to medical care, and the sheer pressure of numbers and work load may force doctors into submission to the demand, even against his better clinical judgement. This is not good for the standards of medical practice and of those standards deteriorate in the end, it is inevitably the patient who will be the loser. There are two areas in particular which at the present time exemplify the pressures upon the doctor to conform to an 'on demand' situation, and which in many instances he must find resistance very difficult even though his clinical knowledge and experience must warn him that he is not necessarily considering the ultimate good of the patient—the prescribing of drugs and control of reproduction. Of course it is only a very tiny minority of doctors who are guilty of yielding to the pressures of those addicted to the so-called hard and soft groups of drugs, but the steadily increasing number of cases occupying the time of the Disciplinary Committee of the General Medical Council is disturbing. More widespread, however, is the overprescribing of the tranquilisers, sleeping pills and antibiotics. I have every sympathy with and understanding of the situation that confronts the doctor, but no one can regard it as the practice of good medicine simply to treat a symptom without the time or opportunity to discover the cause. The second area of enormous pressure on the doctor is in regard to demands for contraceptives, sterilisation and abortion. Again in the majority of such instances the demand is doubtless reasonable and right, but what is the doctor's position if a 12-year-old demands the pill or a 16-year-old wants to be sterilised? Rare examples you may say, and extreme, but they are happening, and happening with increasing frequency, and doctors are coming

more and more under criticism in public and in private, if they preserve their traditional right to advise and not necessarily to accede.

3. No one would doubt that it should be society's aim to improve the quality of the life of its citizens. But what do we really mean by the quality of life? To the many it means a bigger paypacket, a better car, or a greater supply of all the paraphernalia of modern technological gadgetry, and then more and more leisure hours. The quality of life is judged in purely materialistic terms. But if you study the catalogue of diseases and disorders that doctors are called upon to treat, affluence does not by any means spell wellbeing or health. Obviously we still have a way to go before poverty and consequent malnutrition and deficiency diseases are eliminated in this country, but by and large we, in common with other societies in the western world are vastly more affluent than our predecessors were, two or even one generation ago. But we are rapidly replacing the diseases which have been eliminated or whose incidence has been greatly reduced, by those which the affluence of society is creating. Malnutrition is being replaced by obesity and diabetes; osteomyelitis by bones broken in road and other accidents; high multiparity by sterility resulting from some of the consequences of sexual permissiveness; pneumonia by bronchitis and lung cancer due to cigarette smoking and other atmospheric pollutants. The list could go on—and what of the enormous volume of stress disorders? In trying to deal with this new fund of clinical material it seems to me that the doctor's role must inevitably change direction, away from the traditional one of curative medicine into the wider field of prevention. Not only is the field wide but it is also very difficult. Enormous strides have of course been taken, in reducing the incidence of so many epidemic and communicable diseases by public health measures such as mass inoculations, mass radiography, improved pre-natal and infant welfare care, better control and prevention of industrial diseases and in many other ways. But medicine is fast coming to the end of that particular road, and the only way in which much progress will be made in reducing so many of the disorders doctors are called upon to treat now, is by influencing human behaviour. Reference to a few figures relative to two disorders currently increasing rapidly in our society highlights not only the problem but also the difficulties involved in trying to deal with it. The exact incidence of obesity in the population is difficult to estimate not least because of the lack of an exact definition. But many figures have been collected by life insurance companies, and one study in 1968 carried out on the employees of the British Petroleum Company revealed that 48 per cent of the males and 46 per cent of the females were significantly above the desirable weight by age and sex. The majority of these individuals are suffering from simple obesity due to over-eating, the wrong sort of eating and often over consuming alcohol. Does this sort of obesity matter—"Let me have men about me that are fat"? But if you look at the disorders that stem from obesity that are taking more and more of the resources of medical time and the country's finance, it seems that it does matter. From the national point of view perhaps the increased mortality does not matter, but the morbidity and suffering arising from hypertension, skeletal disabilities, metabolic disorders and the complications of surgery on the obese must be enormous.

Between 1954 and 1969 there was a 330 per cent increase in the incidence of gonorrhoea; in 1970 the increase over 1969 was a further 20 per cent, and in 1971

a still further 40 per cent. Does this matter? Alexander Fleming is reputed to have said that the discovery of penicillin had made it possible to catch a fresh infection three times a week, and this seems to be the attitude of some sections of the public. But unhappily, with the emergence of an increasing number of drug resistant infections, it is becoming more and more difficult to cure infection three times a week, and many cases in the female are asymptomatic or are associated with other less serious types of infection and so are being overlooked in the acute or subacute stage. Again the increasing volume of the doctor's time, human suffering, and national resources in dealing with the late complications of this and other preventable pelvic infections is increasing every day. Again the steadily increasing numbers of unplanned pregnancies, most of which should be preventable, tells the same story. The diseases and disorders of the human body and mind that are self-inflicted is of course no new problem in society, nor is the contemptuous attitude of many of the public to doctors and others who try to influence behaviour. Plato recognised it when in his Republic we read "They deem him their worst enemy, who tells them the truth, which is simply that unless they give up eating and drinking and wenching and idling, neither drug nor cautery nor spell nor amulet nor any other remedy will avail". Doctors have by and large tended to cold shoulder "Health Education", and it has remained a Cinderella on the fringe of medical practice and often left in the hands of those least equipped to handle it. But I believe it is now gaining the recognition it should surely be given and doctors must become more and more involved. Time is being found in the undergraduate curriculum for introducing study of the behavioural sciences in many medical schools, and it is encouraging to know that in some measure due to the constant prodding from the Society for Health Education and other bodies and individuals, the first Chair in Health Education in this country is to be established in the new Medical School at Nottingham later this year. But apart from the need to study more about the underlying causes of deviations in human behaviour at an academic level, there is also at the practical level the need to study the best techniques whereby to attempt to influence people. In this respect the doctor is still a person of great authority in the community, and perhaps unexpectedly among the lower social classes. One social study in relation to cervical cytology illustrates this point. The study covered a series of women presenting themselves for cervical cytology, and showed that in Social Classes 1 and 11 nearly 70 per cent had been motivated by what they had read in newspapers or heard on television or radio; whereas in Social Class V it was less than 20 per cent. On the other hand in Social Class V over 60 per cent were first informed and motivated to have the test done by family or clinic doctors. There is evidence from more than one direction that as the standards of living—material, cultural and educational—improve, the stature and influence of the doctor in society tends to decrease. He may well regain some of that lost ground if he takes a more realistic and understanding role in regard to public education in the promotion of health.

4. I made reference previously to what is now spoken of and written about with increasing frequency—the quality of life. Are doctors doing all they should to promote that ideal? Are they perhaps sometimes unmindful of the consequences of some lines of therapy made possible only because of scientific progress? Have we become perhaps too obsessed with mortality, the lowering of which has become

the be-all and end-all of our endeavours? To preserve life and to prolong life are of course the long cherished ideals of our profession, and it is only with some considerable misgiving that one should attempt to challenge them. I can well remember an occasion in the United States some 15 years ago, when a particularly massive operation for terminal cancer was under discussion. The speaker was reporting with some pride that he had reduced the primary mortality in his recent series from 50 per cent to 40 per cent, and I was constrained to remark that I was not so much worried by those patients who died, but by those who survived for a few months only and in great pain and distress. Scientific progress is making it more and more possible to look upon the body as an exciting machine, with limitless opportunities to study, examine and research into the way it works. Without such opportunities and the initiative and enthusiasm of doctors to research and to strive to know and to understand progress would cease. Any attempt to obstruct medical research would be disastrous. Nevertheless it is of the utmost importance that those who carry out research involving patients do not offend against the codes of ethical practice laid down and generally accepted by the profession itself, or against the naturally sensitive feelings of the public without adequate communication. How difficult communication can be is well exemplified by the recent revival of the anxieties aroused in some members of the public by the use of the foetus obtained by abortion for research purposes—and this in spite of a report produced last year by a Committee set up by the Department of Health which spent 18 months of intensive study of the problem, and which spelt out all the facts in detail. Nevertheless one can forgive the public if they sometimes wonder what the doctors are really up to, when they see the results of some of the operations for spina bifida and hydrocephalus in neonates, when they see de-humanised automata salvaged from road accidents, and the prospects of even more survivors into old age, stuffed as one writer has expressed it, with an ever-increasing number of other people's unwanted organs. The public has I think the right to be concerned with some of the more elaborate surgical procedures and intensive care designed purely to prolong life. These impinge on many areas—the progress of scientific medicine on the one hand, the ethical and social consequences, priorities in the use of ancilliary staff, priorities in cost allocation and other factors on the other. When as sometimes happens, the whole surgical work of a hospital may be held up for 24 hours or more, with diversion of staff from other duties in order to allow some extensive surgical procedure, often experimental in nature, and often only likely to prolong life for a few weeks or months, one can understand the public when they ask—is this sort of thing necessary, is it desirable, is it right, is it sensible? The need for the profession to communicate properly, in order to allay anxieties and suspicions is vital—otherwise there will be more and more lay interference in decisions that ought to be purely medical ones. And within the profession itself there is a danger of a dichotomy of interests between those dedicated to the progress of medical knowledge to be applied for the benefit of the individual, and those with a more socialogically orientated outlook, whereby the benefit of society as a whole should over-ride those of the individual. Perhaps these devisions are more apparent than real, but they certainly appear very much to exist, and bring me to another point for reference to possible dilemmas. How far should doctors become involved in trying to influence what are fundamentally

political decisions? I was surprised to read recently in a statement put out by the doctors' group on population that "population should rightfully be the concern of Government". Surely it always has been and always will be. It is obviously right that doctors, who have contributed in no small measure to the growing population in the world by lowering mortality and reducing death rates, especially in infants and the elderly, should do all they reasonably can to control excessive birth rates. But equally I do not think that this should be with the object of helping Government to escape their responsibilities for the social and economic progress of the people they govern. The tendency in population statistics is merely to count heads. Even there the population prognosis made in 1960 for this country proved by 1970 to be out by many millions and little research appears to have been published, if indeed it has been done, on the effects that a rapidly falling birth rate will have on the distribution of population in regard to age, social class, religion and race. I believe the doctor's role is still primarily with his or her individual patient, and not to become the tool of Government in trying to interfere with human reproduction. And I say that in spite of firmly believing as an individual that Government should do all that is reasonable to discourage excessive reproduction. I have no anxieties if doctors sterilise women when in reproductive terms they feel they have had enough, but I would be very disturbed that doctors should sterilise women or men simply because Government wants to reduce population, or does not like the colour of the skin of a section of the population or for any other purely political reason. That would put the profession on a very slippery slope.

In conclusion I should like to make reference very briefly to some of the ethical and medico-legal problems that are causing many doctors great difficulty to-day. Attitudes in society are fast changing. It is not for me to argue whether these changes are for better or worse, but the fact that they are changing makes it necessary for the profession itself to examine some of its traditional ethical codes. The fact that it has stood for over 2,000 years in all societies means, I think, that it should not be cast aside too easily, but should not prevent it from being re-examined and perhaps modified in some respect. One of the features of a profession is that it accepts the responsibility for establishing and maintaining its own standards. As a profession we have done pretty well in this area in this country and we have little of which we have any cause to be ashamed. This makes it all the more unfortunate that internal squabbles within the profession have made it necessary for Government to step in and set up an enquiry into how the profession should regulate itself or be regulated. This cannot enhance the stature of the profession in the eyes of the discerning public, most of whom are bewildered by what the doctors are quarrelling about. A complete lecture would be necessary to cover the whole field of ethics and legal responsibilities, and I shall not attempt this here. I merely list some of the more important areas that must be examined and critically reassessed, largely because we have a comprehensive National Health Service in existence, primarily for the benefit of the public. Professional confidentiality, advertising, prescribing, personal relationships between doctors and patients of the opposite sex, human experimentation, and the problems of preserving life at all costs and regardless of consequences, are the principle ethical problems requiring examination. No one would deny the right to compensation for negligence, but in this technological age we need a much more sensitive mechanism than

exists at present to determine continuing competence to practice, and to determine at just what point patient care falls below generally accepted standards.

I began my remarks with a quotation and I should like to end with one—written by the late Lord Brain on the National Health Service. "We for our part should not let ourselves be obsessed by the Health Service, but remember how much medicine has outside it. We cannot live by our traditions alone, but it is vital that our traditional values, embodied in our great institutions should flourish and be seen to flourish in complete independence. Medical research will continue to grow from strength to strength. Moreover in the modern world increasing numbers of issues touching human welfare have medical aspects, which means that doctors have a unique contribution to make to such debates; since no one else possesses the intimate knowledge of the whole man, body and mind. Medicine is, and will remain, a great and growing tree of which the Health Service is but one of its many branches".